WHO Global Code of Practice & the EC Brain Drain to Brain Gain Project

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International Migration of Health Personnel

I. WHO Global Code, 2nd round of national reporting
II. Recent Evidence
III. Reflections on way forward
II. WHO Global Code, results from 2nd round of national reporting
WHO Global Code of Practice

- Adopted in May 2010 through consensus by the 193 WHO Member States
  - Only the second instrument of its kind promulgated by the WHO
  - Broadest possible articulation of the challenges: elaboration of ethical norms, principles, and practices.
Code Structure and Substance

- Preamble
- Article 1: Objectives
- Article 2: Nature and Scope
- Article 3: Guiding Principles
- Article 4: Responsibilities, Rights and Recruitment Practices
- Article 5: Health Workforce Development and Health Systems Sustainability
- Article 6: Data Gathering and Research
- Article 7: Information Exchange
- Article 8: Implementation of the Code
- Article 9: Monitoring and Institutional Arrangements
- Article 10: Partnerships, Technical Collaboration, and Financial Support

Increased self reliance
Evidence and information
Solidarity
Legal and Institutional Arrangements

• While the WHO Global Code is voluntary, it contains a robust process for reporting
  – WHO’s reporting on the Code is mandatory (“shall”)

• Progress on the Code is to be reported upon at the World Health Assembly periodically
  – 2015: First review of Code Relevance & Effectiveness
Select Findings EAG Report

WHO Global Code is highly relevant, especially in the context of growing regional and inter-regional labour mobility.

Evidence of the effectiveness of the Code is emerging in some countries.

Low awareness, advocacy and dissemination of the Code in other countries – as suggested by the limited response to the first round of reporting – should be addressed.

The work to develop, strengthen and maintain the implementation of the Code should therefore be viewed as a continuing process for all Member States and other relevant stakeholders.
## Increasing Legitimacy and Value

37% increase in countries appointing NDAs

32% increase in countries submitting complete national reports

Reports publically available

<table>
<thead>
<tr>
<th>Region</th>
<th>2012-2013</th>
<th>2015-2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>African</td>
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<td>South-East Asia</td>
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<td>6</td>
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<td></td>
<td>6</td>
<td>7</td>
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<td>European Mediterranean</td>
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<td>12</td>
<td>31</td>
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<tr>
<td></td>
<td>43</td>
<td></td>
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<tr>
<td>Eastern Mediterranean</td>
<td>5</td>
<td>3</td>
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<td>8</td>
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<td>14</td>
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<td>Western Pacific</td>
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<td>4</td>
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<td>43</td>
<td>74</td>
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<td>117</td>
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</tbody>
</table>

**Completed National Reporting Instrument**
Migrant health personnel enjoy the same legal rights and responsibilities as domestically-trained health personnel (Article 4)
Countries undertaking measures to educate, retain and sustain domestic health workforce (Article 5)
Migrant health personnel are hired, promoted and remunerated based on objective criteria as domestically-trained health personnel (Article 4)
Countries adopting measures to address geographical mal-distribution and improve retention in underserved areas (Article 5)
Mechanisms exist to regulate the authorization to practice by migrant health personnel and maintain statistical records (Article 7)
Migrant health personnel enjoy the same education, qualifications and career progression opportunities as domestically-trained health personnel (Article 4)
Statistical records of health personnel whose initial qualification was obtained in a foreign country (Article 7)
Actions have been taken to communicate and share information across sectors on recruitment and migration (Article 9)
Recruitment mechanisms allow migrant health personnel to assess the benefits and risks associated with their employment (Article 4)
Government and/or nongovernment programmes or institutions are undertaking research in migration (Article 6)
Measures have been taken to involve all stakeholders in decision-making processes involving migration and international recruitment (Article 8)
Actions are being considered to introduce changes to laws/policies to conform with the Code recommendations (Article 8)
Database of laws and regulations related to international recruitment in place (Article 7)
Records are maintained of all recruiters authorized to operate (Article 8)
Countries receiving/requesting assistance from other countries or stakeholders to support the Code implementation (Article 10)
Bilateral Agreements

National Reporting Instruments (n=74)

- 34 countries identified existence of bilateral and multilateral agreements

- 22 Countries reported taking into account ethical considerations (education and training programme most commonly mentioned)

- 65 bilateral agreements, duplications excluded, were identified in NRI reports
Key Messages from 2\textsuperscript{nd} Round

- Significant improvement in the quality and quantity of national reporting
  - Strengthening legitimacy and value

- Requests for technical assistance

- Targeted support fundamental

- Significant potential to capture data on in-migration
  - Name and encourage
  - 3\textsuperscript{rd} Round of National Reporting
II. Recent Evidence
Key Sources

- OECD, International Migration Outlook, 2015

- 2nd Round of Reporting WHO Global Code of Practice on the International Recruitment of Health Personnel

- EC Brain Drain to Brain Gain Project
  - India (Kerala), Ireland, Nigeria (Cross River State), Uganda, and South Africa
Share of foreign trained doctors in OECD countries
2013 or latest year available

Source: OECD, 2015
### International migration on the rise

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Doctors</td>
<td>19.5 %</td>
<td>22 %</td>
</tr>
<tr>
<td>Nurses</td>
<td>11 %</td>
<td>14.5 %</td>
</tr>
</tbody>
</table>

The number of migrant doctors and nurses working in OECD countries has **increased by 60%** over the past 10 years (from 1,130,068 to 1,807,948).

**Nigeria**
- Expatriation rate nurses: increase from 10% to 17%
- Expatriation rate physicians: stable at 12%, but doubling in absolute terms
Demand, need and supply

Need
SDG threshold = 4.45 doctors, nurses, midwives

Supply

Demand
Deficit
Insufficient demand to employ workforce to meet needs

Insufficient supply to meet demand
Global economy is projected to create around 40 million new health sector jobs by 2030\(^1\)

Projected shortage of 18 million health workers

High income

Upper-middle income

Lower-middle income

Low income
Things Change: Germany

Fig. 9.1 Medical doctors from selected countries registered in Germany, 1995–2012

Source: German Federal Chamber of Physicians, unpublished data. 2013.
Things Change: UK, new international nurses
Diversity in Destination Countries

2nd Round Code Reporting, Reliance on Foreign Trained Health Professionals

Over 10%: Maldives, Kiribati, Micronesia and South Africa
Over 20%: Belize and Trinidad and Tobago
Over 50%: Namibia and Singapore

Inter-regional movement, foreign-trained doctors
- 2/3 of Argentina’s foreign trained doctors from Bolivia and Colombia
- 1/5 of foreign trained doctors in Kiribati from Fiji
- 1/4 of foreign trained doctors in Trinidad and Tobago from Jamaica

Source: Kadama et al, Rao et al, EC Brain Drain to Brain Gain Project Case Studies
Kerala Emigration

Analysis of Kerala Migration Survey

• 19.4% estimated emigration rate (n=4,175)
  – Education at time of migration: 92% undergraduate degree holders, 8% postgraduate degrees
  – Current Education: 74% undergraduate degree holders, 16% postgraduate degree holders

Doctor Cohort Study (2010 Graduating Class, 4 Medical Schools)

• 5% emigration rate (higher in private medical college)
  – 97% response rate (WhatsApp)

Source: Rao et al, EC Brain Drain to Brain Gain Project Case Studies
# Ireland: Demographics and emigration?

**Table 8: Age category of doctors exiting the register (2014-2015). Source: MCI [6-7]**

<table>
<thead>
<tr>
<th>Age</th>
<th>Exit rate 2014</th>
<th>Exit rate 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Irish medical school</td>
<td>EU medical school - EU National</td>
</tr>
<tr>
<td>&lt; 25</td>
<td>0</td>
<td>0(0%)</td>
</tr>
<tr>
<td>25-34</td>
<td>157 (5.5%)</td>
<td>74 (15.9%)</td>
</tr>
<tr>
<td>35-44</td>
<td>131 (4.3%)</td>
<td>54 (10.2%)</td>
</tr>
<tr>
<td>45-54</td>
<td>36 (1.6%)</td>
<td>33 (8.4%)</td>
</tr>
<tr>
<td>55-64</td>
<td>49 (2.5%)</td>
<td>20 (8.8%)</td>
</tr>
<tr>
<td>65 +</td>
<td>95 (8.5%)</td>
<td>12 (14.3%)</td>
</tr>
</tbody>
</table>

Source: Brugha and Walsh, EC Brain Drain to Brain Gain Project Case Studies
Diversity in Source

Uganda

Distribution of GPs in Uganda by Continent of Training (2010-2015)

South Africa

Foreign-trained medical practitioners, HPCSA 2015: 11.9% of total, from 60 plus countries

Leading source countries

<table>
<thead>
<tr>
<th>Year</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>British</td>
<td>4.22%</td>
<td>4.90%</td>
<td>5.47%</td>
<td>6.05%</td>
<td>5.69%</td>
</tr>
<tr>
<td>Cuban</td>
<td>3.52%</td>
<td>3.77%</td>
<td>3.77%</td>
<td>4.75%</td>
<td>5.34%</td>
</tr>
<tr>
<td>DRC</td>
<td>4.96%</td>
<td>5.05%</td>
<td>5.03%</td>
<td>4.93%</td>
<td>5.00%</td>
</tr>
<tr>
<td>Nigeria</td>
<td>7.39%</td>
<td>7.22%</td>
<td>7.49%</td>
<td>7.33%</td>
<td>7.47%</td>
</tr>
<tr>
<td>Total Foreign</td>
<td>5004</td>
<td>5066</td>
<td>5046</td>
<td>5238</td>
<td>5164</td>
</tr>
</tbody>
</table>

Source: Kadama et al, Mahlati et al, EC Brain Drain to Brain Gain Project Case Studies
# Relevance of Temporary Migration

<table>
<thead>
<tr>
<th>Country of BMQ</th>
<th>Practicing within the Republic of Ireland only, 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ireland</td>
<td>90.2%</td>
</tr>
<tr>
<td>Pakistan</td>
<td>62.1%</td>
</tr>
<tr>
<td>Sudan</td>
<td>53.2%</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>65.5%</td>
</tr>
<tr>
<td><strong>South Africa</strong></td>
<td><strong>18.4%</strong></td>
</tr>
<tr>
<td>Romania</td>
<td>56.5%</td>
</tr>
<tr>
<td>India</td>
<td>72.3%</td>
</tr>
<tr>
<td>Nigeria</td>
<td>63.1%</td>
</tr>
<tr>
<td>Egypt</td>
<td>53.7%</td>
</tr>
<tr>
<td>Poland</td>
<td>69.2%</td>
</tr>
<tr>
<td>Hungary</td>
<td>61.2%</td>
</tr>
</tbody>
</table>

Source: Brugha and Walsh, EC Brain Drain to Brain Gain Project Case Studies
Globalization of Medical Education & Hierarchy

Of doctors registered in Ireland
- 290 BMQ Romania; 44% Romanian nationals
- 91 BMQ Hungary, 15% Hungarian nationals
- 63 BMQ in Poland, 42% Polish nationals

Ratio of trainee specialist division to general (service) posts
- BMQ UK and Ireland, 80:20 ratio
- BMQ most EU countries, 50:50 ratio
- BMQ India, Pakistan, Romania, Sudan, 20:80

Source: Brugha and Walsh, EC Brain Drain to Brain Gain Project Case Studies
III. Reflection on way forward
Lessons from Paris

A unique instrument for global cooperation
- Issue of global concern
- Loss and damage
- Shift of focus: compliance to enhanced transparency framework
  - Naming and shaming to naming and encouraging

How can we better support and strengthen Code implementation?
Innovative Practice

South Africa – Cuba Health Cooperation Agreement
- Cuban doctors practicing in SA plus 900 4th year medical students currently training in Cuba

Sudan – Saudi Arabia Agreement
- Links recruitment and training
- Supports return

Africa Health Placements
- Has placed over 2750 medical graduates, largely from the UK and North America in service in vacant salaried posts in South Africa
- Facilitates recognition of qualification and enables practice for refugees
  • 430 refugee physicians from DRC
5 immediate actions by March 2018

1. Secure commitments, foster intersectoral engagement and develop an action plan
2. Galvanize accountability, commitment and advocacy
3. Advance health labour market data, analysis and tracking in all countries
4. Accelerate investment in transformative education, skills and job creation
5. Establish an international platform on health worker mobility
Acknowledgment

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Thank you

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